1. Corporate Information

AMERIGROUP Corporation
4425 Corporation Lane
Virginia Beach, Virginia 23462-3103
Ph: (757) 962-6459
Fax: (757) 557-6743
jsingle@amerigroupcorp.com

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

Not applicable.

3. State of incorporation or where otherwise organized to do business

AMERIGROUP Corporation is incorporated in the State of Delaware with health plan subsidiaries in Florida, Georgia, Illinois, Maryland, New Jersey, New York, Ohio, Texas, Virginia, and the District of Columbia.

4. States where currently licensed to accept risk and a description of each license

AMERIGROUP Corporation is currently licensed to accept risk in the states listed below. A description of each license is also included.

State	Description of Each License
Florida	Certificate of authority to transact business as an HMO
Georgia	Certificate of authority to transact business as an HMO
Illinois	Certificate of authority to transact business as an HMO
Maryland	Certified to participate in the Health Choice Program
New Jersey	Certificate of authority to transact business as an HMO
New York	Certificate of authority to transact business as an HMO
Ohio	Certificate of authority to transact business as an HMO
Texas	Certificate of authority to transact business as an HMO
Virginia	Certificate of authority to transact business as an HMO
District of Columbia	Certificate of authority to transact business as an HMO

5. Contact Information

John Singleton
National Vice President Government Markets
Ph: (757) 962-6459
Fax: (757) 557-6743
jsingle@amerigroupcorp.com

6. Program Experience - General

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

Yes. AMERIGROUP has more than 10 years' experience operating under capitated arrangements with our state clients. Unlike many managed care organizations that concentrate on commercial lines of business, AMERIGROUP focuses exclusively on the TANF, SCHIP, ABD/SSI, uninsured (FamilyCare), and Medicare Special Needs Program (SNP) populations. AMERIGROUP has developed the expertise in serving public sector populations allowing us to become the largest publicly-traded company focused solely on Medicaid and other publicly-funded healthcare programs. Our success is a result of achieving high member and provider satisfaction, building deep community relationships, establishing strategic partnerships with state regulatory and legislative agencies, developing replicable processes and standardized systems through our operational excellence program, and developing effective, targeted case and disease management programs. Our integrated medical management model is designed specifically for the Medicaid population. Details about this model are provided throughout this RFI response.

Below we list our current clients and indicate the corresponding initial contract start dates. For membership information, please see our response to Question #8.

Current Client List	Client Since:
District of Columbia *(Medicaid, SCHIP, FamilyCare)* District of Columbia Department of Health Medical Assistance Administration	08/01/99
Florida *(Medicaid)* Agency for Healthcare Administration	01/01/03
Florida *(SCHIP)* Florida Healthy Kids Corporation	01/01/03
Florida *(SSI)* Florida Dept of Elder Affairs	01/01/03
Georgia *(Medicaid, SCHIP)* *Department of Community Health*	Operations begin 04/2006
Illinois *(Medicaid SCHIP)* Illinois Department of Public Aid Bureau of Contract Management, Managed Care	04/01/96
Maryland *(Medicaid, SCHIP, SSI)* Maryland Department of Health and Mental Hygiene (DHMH)	06/01/99
New Jersey *(Medicaid, SCHIP, FamilyCare, SSI)* New Jersey Department of Human Services	02/01/96
New York City *(Medicaid)* New York City Department of Health and Mental Hygiene (Operating since 1996; acquired by AMERIGROUP 01/05)	01/01/05
New York *(Medicaid)* State of New York Department of Health (Operating since 1996; acquired by AMERIGROUP 01/05)	01/01/05
New York *(SCHIP)* State of New York Department of Health (Operating since 1996; acquired by AMERIGROUP 01/05)	01/01/05
New York *(LTC)* State of New York Department of Health (LTC program operations begin 12/01/05)	08/31/05

Current Client List	Client Since:
Ohio *(Medicaid, SCHIP)* Ohio Department of Jobs and Family Services	08/01/05
Texas *(Medicaid)* Texas Health and Human Services Commission Fort Worth Travis Dallas Houston (SNP – live 01/01/06)	 09/01/96 06/01/04 07/01/99 12/01/97
Texas *(SCHIP)* Texas Health and Human Services Commission	05/01/00
Texas *(SSI/STAR+PLUS)* Texas Health and Human Services Commission	01/01/98
Virginia *(Medicaid, SSI)* Virginia Department of Medical Assistance Services	07/01/05
Virginia *(SCHIP)* Virginia Department of Medical Assistance Services	07/01/05

All responses from this point forward (6.b through 11.J.2) contain information *proprietary and confidential* to AMERIGROUP Corporation.

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

AMERIGROUP Corporation is in the process of applying for accreditation in 2006 and will achieve NCQA accreditation for our Georgia, Virginia, and the District of Columbia health plans in 2007. Additionally, AMERIGROUP is seeking NCQA accreditation nationally for our disease management programs. By mid 2006, eight of our disease management programs will be NCQA accredited (Asthma, CHF, Diabetes, HIV, Coronary Artery Disease, Chronic Obstructive Pulmonary Disorder, Major Depressive Disorder, and Schizophrenia; as well as our high-risk OB program Taking Care of Baby and Me). Should AMERIGROUP be selected as an MCO for the TennCare Middle Tennessee program we are willing to become NCQA accredited within a reasonable period of time after contract award.

AMERIGROUP Corporation many years experience with HEDIS and CAHPS. In 2005, we conducted six CAHPS surveys, only one of which was required by the state. We maintain a team of very qualified quality improvement specialists to support our HEDIS reporting initiative. Our corporate Clinical Quality Management Department, which is responsible for HEDIS and other Quality Improvement reporting, is staffed by highly skilled professionals with both clinical and data analysis expertise. They are supported by our dedicated Clinical Informatics Department, managed by a biostatistician and staffed by expert clinical informatics professionals with a range of experience including clinical, medical economics, database design, data analysis, provider profiling, and health information. Health plan quality management staff provide clinical quality expertise and data collection and analysis at the local level.

As an experienced Medicaid managed care organization, AMERIGROUP monitors HEDIS Medicaid measures in each domain and annually submits audited HEDIS results to NCQA. Using our team of quality improvement specialists and our internal management information systems, AMERIGROUP will ensure a report is generated for all required HEDIS measures. We use an NCQA-certified software vendor to ensure the strictest adherence to the NCQA technical specifications for HEDIS reporting, including the most recent version of HEDIS measures. A separate certified HEDIS auditing firm audits our results before we report them to NCQA.

On an annual basis, our Quality Management Performance Reporting group contracts with an NCQA-certified vendor for the administration of the most current version of the Consumer Assessment of Health Plans Study (CAHPS), the HEDIS satisfaction survey instrument. If appropriate, supplemental questions are developed and included to address population-specific issues with regard to member satisfaction. The survey is administered by our vendor to a random sample of members who have been continuously enrolled with AMERIGROUP for six months during the reporting year.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

AMERIGROUP currently holds ten contracts with nine states and the District of Columbia to provide Medicaid services. AMERIGROUP focuses exclusively on the TANF, SCHIP, ABD/SSI, uninsured, and Medicare Special Needs Program (SNP) populations. Please see our list of clients provided in our response to Question 6.a.

7. Medicaid Program Experience – Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

a. **Physical Health Benefits**
b. **Dental Benefits**
c. **Vision Benefits**
d. **Non-Emergency Transportation**
e. **Behavioral Health Benefits**
f. **Pharmacy Benefits**
g. **Long-Term Care Benefits (nursing facility and home and community based waiver services)**
h. **Home Health**
i. **Claims Processing and Adjudication**
j. **Quality Assurance**
k. **Utilization Management**
l. **Case Management**
m. **Disease Management**
n. **Provider Credentialing**
o. **Enrollment Assistance**
p. **Member Services (inquiry, ID cards)**
q. **Member Grievances/Appeals**

The following chart outlines by market services AMERIGROUP provides directly (designated by the letter D) and those provided through a subcontracted vendor (designated by the letter S).

D = Provided directly by AMERIGROUP
S = Provided through subcontracted vendor

Service	DC 6 yrs	FL 2 yrs	IL 9 yrs	MD 6 yrs	NJ 9 yrs	NY 8 yrs	TX 9 yrs	OH 2005	VA 2005
A. Physical Health Benefits	D	D	D	D	D	D	D	D	D
B. Dental Benefits	S	S	S	S	S	S	S	S	N/A
C. Vision Benefits	S	S	S	S	S	S	S	S	S
D. Non-Emergency Transportation	S	S	S	N/A	S	S	S	S	S
E. Behavioral Health Benefits	D	D	D	D	D	D	D	D	D
F. Pharmacy Benefits	D & S	D & S	D & S	D & S	D & S	Rx is FFS; all others covered through PDMI	Rx is FFS and covered by HHSC	D & S	D & S
G. Long-Term Care Benefits	D	D	D	D	D	D	D	D	D
H. Home Health	D	D	D	D	D	D	D	D	D
I. Claims Processing and Adjudication	D	D	D	D	D	D	D	D	D
J. Quality Assurance	D	D	D	D	D	D	D	D	D
K. Utilization Management	D	D	D	D	D	D	D	D	D
L. Case Management	D	D	D	D	D	D	D	D	D
M. Disease Management	D	D	D	D	D	D	D	D	D
N. Provider Credentialing	D	D	D	D	D	D	D	D	D

								D = Provided directly by AMERIGROUP S = Provided through subcontracted vendor	
Service	DC 6 yrs	FL 2 yrs	IL 9 yrs	MD 6 yrs	NJ 9 yrs	NY 8 yrs	TX 9 yrs	OH 2005	VA 2005
O. Enrollment Assistance (Marketing and Mobile Outreach)	D	D	D	D	D	D	D	D	D
P. Member Services	D	D	D	D	D	D	D	D	D
Q. Member Grievances And Appeals	D	D	D	D	D	D	D	D	D

8. Medicaid Program Experience – Population

Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

- **Aged, Blind and Disabled – excluding dual eligibles**
- **Dual Eligibles: individuals eligible for both Medicaid and Medicare**
- **TANF and TANF-Related**
- **SCHIP**
- **Waiver Expansion Population (low-income uninsured)**
- **SPMI (Seriously and Persistently Mentally Ill)**
- **SED (Seriously Emotionally Disturbed Children/Youth)**

AMERIGROUP serves each of the populations listed in Question #8. We do serve members who are Seriously and Persistently Mentally Ill (SPMI) and Seriously Emotionally Disturbed Children/Youth (SED); these members fall under either our TANF, CHIP, or SSI programs. The three tables below provide the populations served for each state in which we have a contract(s), the number of lives for each population, total number of members for each population/product, and total populations served in each of the states we have contracts. These figures represent AMERIGROUP's third quarter membership as of September 30, 2005.

Client Name and Address	Population Served	# Lives (3Q2005)
District of Columbia	ABD/SSI	0
	Dual-Eligibles	0
	TANF	34,900
	SCHIP	2,000
	Waiver Expansion	**3,900
Florida	ABD/SSI	26,900
	Dual-Eligibles	7,000
	TANF	132,500
	SCHIP	56,000
	Waiver Expansion	0
Georgia	Operations begin 04/2006	Operations begin 04/2006
Illinois	ABD/SSI	0
	Dual-Eligibles	0
	TANF	43,300
	SCHIP	300
	Waiver Expansion	0
Maryland	ABD/SSI	15,000
	Dual-Eligibles	0
	TANF	95,600
	SCHIP	25,400
	Waiver Expansion	0
New Jersey	ABD/SSI	6,700
	Dual-Eligibles	1,200
	TANF	36,800
	SCHIP	56,700
	Waiver Expansion	***7,300
New York	ABD/SSI	1,700
	Dual-Eligibles	0
	TANF	79,100
	SCHIP	19,300
	Waiver Expansion	***30,200
Ohio	ABD/SSI	0
	Dual-Eligibles	0
	TANF	800
	SCHIP	0
	Waiver Expansion	0
Texas	ABD/SSI	34,600
	Dual-Eligibles	11,700
	TANF	334,600
	SCHIP	36,000
	Waiver Expansion	0
Virginia	ABD/SSI	2,200
	Dual-Eligibles	0
	TANF	16,800
	SCHIP	400
	Waiver Expansion	0

Note: Figures are rounded to the nearest 100.
* Dual-eligibles also included in the ABD/SSI count
** Adults related to SCHIP/Medicaid children
*** Uninsured adults

AMERIGROUP membership by product as of September 30, 2005 is:

AMERIGROUP Product	Membership by Product
AMERICAID (Medicaid-TANF)	775,000
AMERIKIDS (SCHIP)	196,000
AMERIPLUS (Medicaid-SSI)	87,000
AMERIFAM (FamilyCare)	41,000
Total	1,099,000

Note: Figures are rounded to the nearest thousand

AMERIGROUP membership by state health plan as of September 30, 2005 is:

AMERIGROUP Health Plans	Membership by State
Texas	405,000
Florida	215,000
Maryland	136,000
New York	130,000
New Jersey	108,000
Illinois	44,000
District of Columbia	41,000
Virginia	19,000
Ohio	1,000
Total	1,099,000

Note: Figures are rounded to the nearest thousand

9. Medicaid Program Experience – Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

AMERIGROUP has valuable experience with performance incentives based on targeted health outcome standards. The table below illustrates examples of current AMERIGROUP markets where performance incentives exist.

Client Name and Address	Level of Risk	Financial Incentives
District of Columbia *(Medicaid, SCHIP, FamilyCare)* District of Columbia Department of Health Medical Assistance Administration	Full Risk	Pay-for-performance standards are under development for meeting defined HEDIS standards
Florida *(Medicaid)* Agency for Healthcare Administration	Full Risk	None
Florida *(SCHIP)* Florida Healthy Kids Corporation	Full Risk	None
Florida *(SSI)* Florida Dept of Elder Affairs	Full Risk	None
Georgia *(Medicaid, SCHIP)* Department of Community Health (operations begin 04/2006)	Full Risk	The Georgia Contract provides financial incentives available for exceeding performance measures in several preventive health areas (dental, EPDST, blood-lead, etc.) and newborn notification standards.

Client Name and Address	Level of Risk	Financial Incentives
Illinois *(Medicaid, SCHIP)* Bureau of Contract Management, Managed Care	Full Risk	None
Maryland *(Medicaid, SCHIP, SSI)* Maryland Department of Health and Mental Hygiene (DHMH)	Full Risk	Incentive and "disincentive" payments and withholds are in place for performance in the areas of HEDIS scores, member satisfaction and encounter data.
New Jersey *(Medicaid, SCHIP, SSI, FamilyCare)* New Jersey Dept of Human Services	Full Risk	None
New York City *(Medicaid)* New York City Department of Health and Mental Hygiene	Full Risk	None
New York *(Medicaid)* State of New York Department of Health	Full Risk	None
New York *(SCHIP)* State of New York Department of Health	Full Risk	None
New York *(LTC)* State of New York Department of Health	Full Risk	None
Ohio *(Medicaid, SCHIP)* Ohio Department of Jobs and Family Services	Full Risk	1% of the health plan's premiums are considered "at-risk" and require that the health plan meet all performance incentive standards to retain the at-risk premiums. Standards are established in the areas of quality of care, provider satisfaction, accessibility, consumer satisfaction, and clinical performance. Additional financial rewards are available for plans that exceed required performance measures.
Texas *(Medicaid: Fort Worth, Travis, Dallas, Houston)* Texas Health and Human Services Commission	Full Risk	Effective 09/01/06, the contract provides incentives for exceeding certain quality measures.
Texas *(SCHIP)* Texas Health and Human Services Commission	Full Risk	Effective 09/01/06, the contract provides incentives for exceeding certain quality measures.
Texas *(SSI/STAR+PLUS)* Texas Health and Human Services Commission	Full Risk	None
Virginia *(Medicaid, SSI)* Virginia Department of Medical Assistance Services	Full Risk	None
Virginia *(SCHIP)* Virginia Department of Medical Assistance Services	Full Risk	None

10. Experience – Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

Not applicable. AMERIGROUP currently provides Medicaid program and Medicare SNP services only.

11. Reformed Managed Care Model

A. Behavioral Health

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

Yes, AMERIGROUP currently manages behavioral health services as part of an integrated care management system in eight states and the District of Columbia; we do not rely on subcontracted third-party BHOs. Our care management services are provided to Medicaid and SCHIP recipients, including those with SED and SPMI. Based on more than a decade of research in the managed behavioral health field, it has become evident that a holistic system of care improves the overall level of service to members by integrating the physical, behavioral, and social aspects of treatment to maintain continuity of care. In 2003, we expanded our Behavioral Health Services Division to support the needs of members in various markets. In our New York, Florida, Illinois, Texas, District of Columbia, Ohio, and Virginia health plans, we offer the full continuum of behavioral health services. In Maryland, we provide substance abuse coverage. In New Jersey, we facilitate behavioral health care for members with developmental disabilities. Our successfully implemented care model now offers behavioral health services to more than 800,000 members.

We offer a truly integrated model that blends physical and behavioral healthcare management, resulting in better patient outcomes, reduced administrative costs, and better management of high-cost psychotropic drugs. Our integrated approach begins with the new member Welcome Call and initial health assessment that includes questions related to behavioral health conditions. It continues through our Integrated Medical Management Model (IM3) for case management and extends through claims processing and other operational areas. (Please see our response to Question 2 below for a complete description of IM3.)

Our system provides a level of service to members and to our state clients not possible in the world of separate standalone behavioral health vendors that function as an adjunct to physical health managed care services. Licensed Behavioral Health Case Managers are based in our local health plans. These Case Managers are registered nurses or licensed clinical social workers with at least three years of experience in the behavioral health field. Local Case Managers conduct a comprehensive assessment by telephone or in person. Based on member needs, Care Managers and Case Managers develop care plans that identify psychosocial needs and outline recommended treatment. Members needing assistance with behavioral health issues can call our toll-free Member Services Hotline. Behavioral health calls are immediately routed to our experienced, licensed behavioral health staff on the Behavioral Health Clinical Access Line. Member assistance is available 24 hours a day, 7 days a week for routine, crisis, or emergency calls.

Responsive and accurate claims payment is an important part of provider satisfaction. We have a dedicated, experienced behavioral health claims team within our Claims Department. This team is familiar with the unique aspects of behavioral health care, including provider types and coding, and issues that require coordination between behavioral and physical health services.

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

Medical Management Model. As a result of our ongoing quality improvement efforts and feedback from our health plan Medical Directors and internal and external medical management and behavioral health experts, AMERIGROUP's successful case management programs have evolved into the next generation: the Integrated Medical Management Model (IM3). This expanded model integrates physical, behavioral, and social factors toward the goal of assessing, accurately stratifying, and effectively managing and monitoring members' care.

The cornerstone of IM3 is our *Early Case Finding* (ECF) health assessment process that proactively identifies and stratifies members into appropriate tiers for case management. If the preliminary health screening done during the initial Welcome Call to new members indicates the need for further assessment, members are referred to Case Management. The ECF process includes the use of a configurable, commercially available software tool that allows us to adapt assessment questions to address the specific needs of a state's Medicaid, LTC, and SCHIP populations. The initial health assessment determines a member's needs across three domains – physical, behavioral, and social – and assigns an overall risk score. The risk score ensures members receive appropriate care and that those members needing immediate interventions receive first priority. Based on the acuity score, members are grouped into three risk levels: 1 = Low Risk; 2 = Moderate Risk; and 3 = High Risk. These groups focus medical management efforts on interventions that encompass physical, behavioral, and social factors to address the needs of the whole person, not just an isolated medical or behavioral health condition.

Members designated as Moderate or High acuity are assigned to a Care Coordinator and/or Case Manager, who develops a Plan of Care that fully identifies the member's medical, behavioral, and social needs and recommended treatment. As part of this process, the Care Coordinator/Case Manager consults with the local Medical Director, the member's PCP, any associated specialists who are treating the member, community-based Case Managers who have worked with the member, and the member's family or designated guardian. The Care Plan also includes an associated Services Plan, which specifies exactly what medical, behavioral, and social services are required to maintain and maximize the member's health and functioning. Care Coordinators and Case Managers also evaluate members' needs for social, educational, therapeutic, and other nonmedical services, such as assistance from community organizations, and the support capability and needs of the family.

At each health plan, Behavioral Health and Medical Case Managers meet and attend general medical rounds where specific clinical conditions are discussed. These staff members respond to requests for services from their counterparts as complex clinical conditions arise or when a combination of behavioral health and medical conditions are present. Following this collaboration, they then seek the appropriate services in the provider community and coordinate members' care to include treatment for physical, psychiatric, and substance abuse diagnoses and resultant symptoms.

Cultural Competency. AMERIGROUP has more than 10 years' experience serving members with the wide array of cultural backgrounds represented by states' Medicaid populations. We know that proactively embracing and honoring these cultural differences is vital to successfully serving members' healthcare needs. As a result, we strive to retain existing members and help potential members feel valued, understood, and appreciated. Our cultural competency practices are based on the 14 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the

U.S. Department of Health and Human Services' Office of Minority Health. Our network development strategy includes recruitment of providers whose cultural and ethnic backgrounds reflect the diversity of the Medicaid and SCHIP populations we serve.

We provide member materials in English and Spanish and provide additional formats as needed (including large print, audiotape, and Braille) to accommodate those with visual or hearing impairments, disabilities, or special needs. Members whose primary language is other than English are informed of available translation services through our call answering system, Member Services Associates, the welcome letter, Member Handbook, and other member communications. In addition to our in-house bilingual resources, we contract with two language interpretation services that can immediately join calls with members: Tele-Interpreters on Call and Language Line Services provide language interpretation via telephone 24 hours a day in 160 languages by individuals trained in healthcare terminology. These services are used when AMERIGROUP bilingual Associates are not available or do not speak the requisite language.

3. a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

AMERIGROUP provides coverage and care coordination for members with SED and SPMI. In addition to contracting with individual network providers – psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists – we contract with local programs and facilities offering behavioral health and substance abuse treatment services, including Behavioral Health Specialty Clinics and local Community Service Boards. We work with these organizations to provide community-based outpatient and wraparound services that play an important role in care management for these high-risk members.

All members designated as SED or SPMI are assigned to a Case Manager based in the local health plan. In cases where a member's acuity exceeds even Level 4 criteria, our Behavioral Health Care Managers refer the member to Intensive Case Management to provide additional wraparound services that stabilize the member's condition. The Case Manager follows protocols that coordinate services with community resources that include housing programs, supported education, vocational rehabilitation, family counseling and education, and social support. These services include:

- In-home visits and crisis visits for in-home crisis stabilization
- Coordination and support for provider appointments and recovery support groups
- Coordination and support for obtaining appropriate medications
- Home Nurse visitation to provide medication support and environmental assessments
- Housing assistance and other placement services to promote a recovery-focused living environment
- Social outings and community outreach services.

Some members with severe and chronic mental illness continue to destabilize and return to an inpatient setting within a very short time. An example of successful care coordination for these individuals can be found in our Texas market, where we have initiated the *Rising Star* Program. In this program, the member selects a psychiatrist and a "home" hospital to visit when needing that particular level of care. The program provides the continuity of care especially needed by this population, fosters stabilization of symptoms, and increases independence and self-determination. Members have embraced this program. Feedback indicates they feel less disenfranchised. Psychiatrists have enthusiastically endorsed this program because they can now work with the member over a longer period of time after first completing a comprehensive evaluation to determine the diagnosis and the appropriate course of treatment. Follow-up

is more effective as the member continues to see the same psychiatrist as an outpatient, thus extending the continuity of care. This provides more effective treatment and allows interventions to be made gradually in the context of the individual's needs, rather than as a crisis response without adequate history of the effectiveness of treatment modalities.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

One of the greatest challenges in serving these populations is obtaining adequate data with which to estimate the severity of illness and intensity of need. Accurate data allows adequate funding for the program to maintain at least minimum stability in the community. While there can be an initial contractual estimate of costs of care, this should be reviewed regularly to make adjustments as needed to reflect the needs of this population. The focus should be on innovative programming and providing services with flexibility, since these members often have combined physical, social, and behavioral health needs. The contract should include a requirement for early case finding, intensive case management, acute inpatient, respite, sub-acute and residential inpatient services, as well as a comprehensive array of outpatient services. The provision of group activities, family support, and linkage to community services and community-based programming should be emphasized.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

Individuals with SED and SPMI generally require extensive services. However, AMERIGROUP has successful experience managing care for this population, and we believe they can be effectively served via a fully capitated program. If the rate is adequate and the funds to treat them are available, our interest in bidding would be there. A decision by the State to exclude these individuals would not affect our interest in bidding.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

Given the complexity of their needs, it is very important to have actuarially sound rates to cover this population. With an appropriate rate structure in place, we believe we can positively affect their health outcomes. We have proven capability to serve populations where there are complex, combined care needs, since we have developed the approach and mechanisms to identify them and to appropriately manage their care. If there were a no-risk ASO arrangement for this population, there would be interest as well.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

Since we do not outsource behavioral health services, AMERIGROUP contracts directly with all traditional providers who serve this population. We believe in working with community-based providers and in ongoing community involvement as a means to creating the most effective provider networks. Our behavioral health network development strategy involves contracting with individual providers: psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, and local programs and facilities offering behavioral health and substance abuse treatment services. We invite and include in our network many community-based providers such as Behavioral Health Specialty Clinics and local Community Service Boards that are experienced with the needs and issues unique to the Medicaid

population. Members may self-refer to any of our behavioral health network providers for an initial visit without seeking prior approval from his/her PCP. As necessary, we make special arrangements for consultation with specialty providers in the community and focus on developing and maintaining an adequate network in the areas we serve.

5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

There is currently a severe shortage of adequate behavioral health resources in the United States, in particular, a shortage of child and adolescent psychiatrists that has created problems with obtaining timely appointments. We recommend a rate adjustment that would be more conducive to psychiatrists' practice and thereby create more availability of services for members. We suggest a Pay for Performance approach to the recruiting, contracting, and reimbursement of psychiatrists so that the quality of their work (as measured in admissions and readmissions to hospitals, lengths of stay, and stability once a patient is discharged) are measured and reported. These factors would then reflect on their reimbursement. This would be designed as a quality-of-care focused system and not evolve into a utilization management system.

B. Pharmacy Services

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.

Incorporating pharmacy services into the MCO contract yields the best results for effective care management and responsible cost containment. Our preference would be to manage this benefit internally instead of coordinating with a carved-out pharmacy vendor. However, if the State elects to continue its carve-out PBM contract, AMERIGROUP would offer clinical support in areas such as pharmacy case management, retrospective drug utilization review programs, clinical prior authorization programs, and disease management support. This can be accomplished through transfer of data between the PBM and AMERIGROUP so that AMERIGROUP has access to the pharmacy data in real time. Pharmacy data is integral to effective medical management – it is used to identify high-risk members for referral to case management and disease management programs that have demonstrated success with medical cost containment and improving members' health outcomes. The data will also be used to support provider profiling for education on appropriate pharmacotherapy to large provider practices for diseases such as asthma and diabetes.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

Managing the pharmacy benefit in real time requires real-time access to the incoming claim information. Access to real-time claim information will allow us to manage clinical prior authorization, support clinical edits, provide concurrent drug utilization review, identify high-risk members in need of clinical or pharmaceutical intervention, and capture claim information needed to support the previously described clinical activities.

C. Long-Term Care Services

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.

AMERIGROUP is experienced in serving SSI/ABD populations and with meeting the requirements of states' long-term care programs. We have found that improved health outcomes result from a fully integrated coordination of all aspects of care delivered to the member: long-term care, acute care, and behavioral health services. To ensure this level of integration, reduce service gaps, and prevent duplication of service, AMERIGROUP implements our Integrated Medical Management Model (IM3) described in detail in our response to 11.A.2. Under this model, all members requiring LTC services are assigned to a Care Coordinator or Case Manager (depending on acuity level) after the health assessment at the time of enrollment. These professionals act as consultants, planners, and facilitators for all services, including primary and acute care and LTC services. Case Managers provide intensive management of services associated with acute events such as inpatient hospitalization. They also identify those members who are in acute care (found through hospital rounds or inpatient census reports) and coordinate with the Care Coordinator on discharge planning and developing new or revised Care Plans. Care Coordinators collaborate with attending physicians, including the PCP and physical and behavioral health specialists, to ensure the member receives appropriate services and support. Members in institutional settings are immediately assigned to an AMERIGROUP Case Manager for face-to-face comprehensive assessment and development and implementation of the Care Plan. Care Coordinators/Case Managers contact the member's PCP and other providers to:

- Obtain clinical information
- Develop and communicate the Care Plan
- Discuss the Care Plan before issuing authorizations to ensure there is no overlap with existing services
- Reinforce the need to review and retain the Care Plan in the member's medical record
- Encourage communications with all involved providers regarding the member's treatment.

In addition, Care Coordinators/Case Managers work with hospital discharge planners and providers after a hospital stay to ensure appropriate services are in place in the home or institutional setting.

2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

The best incentive to ultimately drive increased and more appropriate use of home- and community-based care, more effective care management, and cost savings for the State would be to incorporate the management of LTC services into the MCO contract. This total integration of care management offers optimal benefits to members in terms of social and family support and coordination of the complete spectrum of care. It also offers the opportunity for increased preventive care – which can save money by reducing the need for acute care and/or nursing home stays. State Medicaid programs that have had success with this integrated approach include Texas, Arizona, and New Mexico.

We propose establishing a blended rate to cover the entire LTC population (those in institutional and home- and community-based care) instead of a PMPM specific to the nursing home population. This practice supports moving members into less restrictive settings as soon as their condition warrants and removes the "reverse incentive" associated with paying a higher rate for institutional care. The State may also wish to consider a financial incentive for MCOs that develop and attract members to a Consumer-

Directed Care Option for nursing-home-eligible individuals who remain in a home- or community-based setting.

D. EPSDT Incentives

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

AMERIGROUP ensures EPSDT services are provided to all eligible children from birth through age 20 through contractual requirements with PCPs and other providers. Our EPSDT program objectives are to:

- Arrange for the provision of screening services
- Provide health education and reminders for families
- Facilitate appropriate referrals for members who require follow-up care related to an abnormal finding as a result of a screening
- Monitor provider compliance with program requirements
- Facilitate provider education and generate provider support for the program
- Coordinate with PCPs to improve member compliance with the schedule of checkups and immunizations
- Conduct all activities in a culturally competent manner.

In addition to paying provider claims for EPSDT services per established rate schedules, we currently offer EPSDT physician incentives in several markets that include supplemental administration fees for immunizations. Our recommendation is a bonus program based on our Illinois model, which pays rates based on the Market Master Fee Schedule plus a specified bonus amount for certain EPSDT services (based on CPT codes).

AMERIGROUP ensures eligible members receive the appropriate services in a timely manner through member education, member tracking and outreach, and provider education. Educational efforts include AMERITIPs (health information flyers), Health Tips on Hold (recorded health messages on the Member Services Hotline), newsletters, Nurse HelpLine, and flu campaign education. We remind members that EPSDT services are free, and we provide information about how and where to access care. In addition to EPSDT information included in the new member welcome packet (Member Handbook and an AMERITIP about health screenings), during the initial Welcome Call, our Outbound Services Representative explains the importance of health screenings and reminds members to schedule a visit for themselves and their children with the PCP(s). We also send regular EPSDT reminders to parents/guardians. Reminders include:

- **Preventive Care Reminder Cards.** These are sent to members age 0-20, two months prior to their birthday. The cards include birthday greetings, explain the importance of health screenings, identify the screenings and immunizations that are needed at that particular age, and encourage parents/guardians to make an appointment for the member's screening.
- **Reminder Postcards.** If we do not receive a claim for EPSDT services within 90 days of the member's birthday or if a member continues to fail to obtain services during two consecutive quarters, we send a reminder postcard. One is also mailed if no services are obtained within 7 days of a member giving birth.

- **PCP Reminder Letters.** Monthly letters are sent to PCPs with a list of members who are three months out of compliance with the screening/immunization schedule.

AMERIGROUP enhances member outreach through contracts with appropriate community organizations and nonprofit agencies that have demonstrated their ability to reach our targeted population. This includes follow-up with members and their parents when screening appointments with the PCP have been missed, assisting members in arranging appointments or transportation, and minimizing other obstacles to the successful completion of screening activities. EPSDT initiatives are measured and designated as successful when:

- Immunization levels meet or exceed established targets
- Lead screening levels comply with state mandated percentages
- Dental screening services achieve state mandated targets
- The number of members receiving well-care exams meets or exceeds established targets.

Specific initiatives include our:

- **Lead Case Management Program** – verbal screenings by PCPs (Lead Risk Assessment) and guidance to parents/guardians; blood tests at 12 months and 24 months of age and as part of visits between ages 24 and 72 months if there is no prior record of earlier testing. A Case Manager is assigned as needed for those who require a plan of care and treatment.
- **Immunization Program** – Network providers enroll in the state Vaccines for Children (VFC) Program and administer immunizations and vaccines to all members under 21 years of age in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. Data is exchanged with state immunization registries, including the District of Columbia, Illinois, Florida, Maryland, New Jersey, and Texas.

E. Utilization Management/Medical Management (UM/MM)

1. Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.

None of AMERIGROUP's current contracts impose a range of "hard" benefit limits as proposed by the State of Tennessee. Medical and behavioral health services are authorized according to established medical necessity criteria and procedures that ensure cost effective care management. Our utilization and care management programs facilitate the delivery of the right care at the right time in the right setting. Establishing a "medical home" for the member through their PCP is critical to our approach to care management. Our focused programs result in better quality of care, enhanced quality of life for our members, and responsible management of medical costs.

In our Florida market, the state does limit inpatient hospital stays. The health plan is at risk for 45 days per calendar year of inpatient care for both adults and children. After the 45-day limit is reached, the state's Medicaid fee-for-service (FFS) system assumes the risk for a child's additional inpatient stays, thereby providing unlimited coverage for children. Florida's FFS system does not provide additional coverage for adults, so after the 45-day limit is exceeded, an adult member is responsible for any additional inpatient costs incurred. AMERIGROUP Florida coordinates and authorizes inpatient stays for

members according to these terms and assists members and providers when a child's care requires a transition to the FFS system for extended inpatient stays.

Prior Authorization Process. AMERIGROUP's approach to prior authorization promotes appropriate care. Through our aggressive provider-servicing model, we educate our network providers on covered benefits and services and have reduced the number of services that require prior authorization. We require prior authorization on selected services to ensure timeliness and appropriateness of care, including: planned inpatient admissions, certain outpatient surgeries and procedures, nonemergent out-of-network services, certain outpatient referrals to specialists, home health, durable medical equipment, rehabilitation services, managed-access drugs, and certain diagnostic procedures. When a course of treatment will involve services over an extended period, the treating provider includes that information in the initial authorization request. If approved, the authorization will then cover the full course of treatment. Prior authorizations are performed by Precertification Nurses, licensed professionals with training and experience in utilization management for Medicaid and SCHIP programs. They verify eligibility and benefits and apply the appropriate criteria to determine whether the service is medically necessary. For those situations where medical necessity is met, the nurse approves the services. When medical necessity is questioned, the case is referred to the health plan Medical Director for review and consultation with the provider.

AMERIGROUP uses InterQual® criteria to review medical necessity and appropriateness of both physical and behavioral health services. These criteria are an industry standard for medical necessity review and are widely used by health plans, hospitals, and government agencies. They provide a rules-based system for screening proposed medical care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness. We supplement InterQual® criteria with review guidelines from Apollo Managed Care Consultants. Apollo clinical guidelines are evidence-based and supported by extensive references in the peer-reviewed literature. AMERIGROUP uses Apollo medical review criteria for managing care in the following categories: specialty care, physical/occupational therapy and rehabilitation care, pain management, stroke, and cardiac rehabilitation. The AMERIGROUP Approval and Application of Medical Necessity Criteria Procedure is used to apply nationally recognized medical necessity criteria to our decision process for approval of requested services for payment by our health plans. The specific steps include home office Medical Policy Committee review and involvement by local health plan Medical Directors and Medical Advisory Committees.

AMERIGROUP follows established procedures for applying criteria based on individual member needs and community standards of care. These procedures apply to prior authorization, concurrent, and retrospective reviews. Although emergency services do not require preauthorization, we use successful utilization management strategies to reduce emergency room use by members for nonemergency services. We provide assistance to members who over-utilize the emergency room through our ER Frequent User Program. In addition to relying on ER utilization reports to identify and assist frequent users, the reports are analyzed as the basis for creating strategies to achieve emergency room utilization targets consistent with clinical and financial quality indicators. We also use provider and member education to supplement utilization management approaches. Our Nurse HelpLine is available 24 hours a day, 7 days a week, to advise members of procedures for obtaining emergent, urgent, and routine care. The nurses are specially trained to deal with these issues and to refer a member to appropriate resources.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

We recommend that MCOs be permitted to propose to the State a set of alternative levels of care to be used when appropriate to meet members' medical needs. These services are considered to be "soft" benefits that do not necessarily count toward members' annual benefit limits. Many alternative levels of care are for behavioral health services and include the following: partial hospitalization, 23-hour observation beds, intensive outpatient services, and targeted case management. AMERIGROUP works with our state clients to determine the scope of benefits covered under the contract and those that may be offered as alternative care services. These alternative services are clinically based treatments provided by licensed medical professionals. A service may be used as a "flex" benefit and count toward a part of a benefit limitation. For example, partial hospitalization may count as 2:1 ratio against an inpatient stay when the level of care is available.

Extensivist services are another example of "soft" benefit services. The extensivist's role is to aggressively manage the care of high-risk patients – the 5 percent who account for 60 percent of medical expenditures. AMERIGROUP has used extensivist services successfully in our Florida market. These services are provided by licensed nurses, psychologists, and social workers who visit members at home to determine medical and behavioral health factors that may be having an impact on a member's overall health. Through this detailed home-based assessment, early health determinations lead to proactive medical interventions and more effective treatment for seriously ill members.

F. Disease Management

Physical Health

1. Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs?

AMERIGROUP currently provides disease management (DM) programs for eight state Medicaid programs – Florida, Illinois, Maryland, New Jersey, New York, Ohio, Texas, Virginia – and the District of Columbia. Disease management services will be implemented in Georgia with the start of our health plan operations in April 2006.

Again, if yes, on which conditions does your program focus today?

Our currently operating DM programs coordinate care for members with the following conditions:

- Diabetes mellitus
- Congestive heart failure (CHF)
- Asthma
- High-risk obstetrics
- HIV/AIDS
- Organ transplants.

The following programs are in the final development phase for all markets and will enroll members in March 2006:

- Coronary artery disease (CAD)
- Chronic-obstructive pulmonary disease (COPD)
- Major depressive disorder
- Schizophrenia.

2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

Our disease management programs are staffed by qualified professionals at the AMERIGROUP home office and local health plans. We do not subcontract the disease management function to another entity. The home office DM team includes the Director of Disease Management/Operations, Director of Disease Management/Clinical Outcomes, nurses assigned to disease-specific units, coordinators, and support staff. Additional disease management services are provided by local Case Managers in each health plan

3. Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?

AMERIGROUP's disease management (DM) programs currently serve more than 74,000 members in eight states and the District of Columbia. We focus on reducing unnecessary lengths of stay, providing appropriate levels of care, and incorporating outreach, education, and effective discharge planning and follow up. Our programs help improve treatment compliance and enhance self-care and caregiver supports through early identification and screening, assessment and evaluation, prevention and education, and care referrals. AMERIGROUP has extensive experience implementing and maintaining DM programs for Medicaid and SCHIP populations with the following conditions: asthma, diabetes, chronic heart failure (CHF), high-risk OB, HIV/AIDS, and organ transplants. Beginning in March 2006, we will also provide comprehensive DM services to members with CAD, COPD, major depression, and schizophrenia. These programs are integrated with our case management and behavioral health management services.

Disease Management Identification, Outreach, and Education. We are familiar with the transitory nature of the Medicaid population. If the preliminary health screening done during the initial Welcome Call to new members indicates the presence of a specific disease state, members are referred to our Disease Management Program for further assessment and care management. As follow-up to the Welcome Call and *Early Case Finding* health assessment (part of our Integrated Medical Management Model), we implement aggressive outreach efforts to identify and support members who will benefit from disease management and case management services. Members with intensive needs are referred to the Case Management Program, where outreach is initiated within 24 hours. For those members referred to Disease Management, staff make three attempts to contact the member by phone. If phone contact is unsuccessful after 10 days, or a member is without a working phone, Disease Managers send a post card to offer assistance and provide contact information. After 10 additional days of no response, the Disease Manager enlists the assistance of local outreach staff in a final attempt to reach the member.

Members in DM are stratified into mild, moderate, and severe categories. We customize the activities of each program component to meet the specific needs of members at each level. Program components include training, education, behavior modification, medication tracking and reporting, quarterly trend

reporting, automated recommendations, physician exception reports, scheduled coaching calls, participant monthly reports, time-sensitive reminders, and home visits.

UM and Clinical Practice Guidelines for Disease Management. General medical care received by members participating in our disease management programs is subject to the same utilization management requirements as applied across the board. Our clinical reviewers always consider comorbidities when applying UM guidelines, whether or not those comorbidities are associated with one of our DM programs. Our DM activities often focus on activities that do not require authorization, such as education, coordination, and promoting preventive care services. In addition, PCPs can refer members to specialty care related to their disease state without obtaining prior authorization.

As part of AMERIGROUP's Quality Improvement Process, clinical practice guidelines are developed for our provider network. Guidelines are based on those developed by specialty societies such as the American College of Obstetricians and Gynecologists and on community standards. They are reviewed annually and approved by the Medical Advisory and Quality Management Committees. Once adopted, clinical guidelines are made available on our *Provider ASSIST* website and are sent to providers upon request. Information on AMERIGROUP clinical guidelines is presented as part of provider orientation and training sessions in all our markets. Practice patterns may be measured against these guidelines.

Care Coordination for Diabetes. Our DM interventions by risk level for diabetes are shown in the following chart.

Process	Level I - Low	Level II - Moderate	Level III - Severe
Interventions	Complete initial assessment. Assess for DME supplies (glucometer) & education needs. Stress importance of PCP visits, labs, dilated eye exam	Complete initial assessment Assess for glucometer & education needs; if needed, home health visit to provide education on diabetes & use of glucometer for homebound Stress importance of PCP visits, labs, dilated eye exam	Complete initial assessment Assess for glucometer & education needs; if needed, home health visit to provide education on diabetes & use of glucometer for homebound Refer to case management when indicated
Education	Refer to diabetes class or reinforce earlier education Advise on community resources as needed Give Nurse HelpLine number Mail AMERITIPS on diabetes or other appropriate literature	Refer to diabetes class or reinforce earlier education Advise on community resources as needed Give Nurse HelpLine number Mail AMERITIPS on diabetes or other appropriate literature	Refer to diabetes class or reinforce earlier education Advise on community resources as needed Give Nurse HelpLine number Mail AMERITIPS on diabetes or other appropriate literature
Telephonic Care Coordination	Call 1 week after member admitted to hospital or ER visit, then contact every 6 months	Initially contact monthly When member stable, contact every 2-3 months	Will vary-contact every 1-2 months Coordinate with adult case manager
PCP Communication	Program Coordinator contacts PCP to discuss program, referrals, and services Communicate any changes in member's condition	Program Coordinator contacts PCP to discuss program, referrals, and services Communicates any changes in member's condition	Coordinate with case manager contacting PCP to discuss program and development of treatment plan and communicate any changes in member's condition

Care Coordination for Congestive Heart Failure. Our DM interventions by risk level for congestive heart failure are shown in the following chart.

Process	Level I and II - Mild	Level III - Moderate	Level IV - Severe
Interventions	Complete initial assessment Assess for risk severity, presence of cardiac disease and limitations on activity. Provide all members a scale	Complete assessment 1 home visit by HHA (Home Health Agency) nurse. Call frequently to monitor symptoms, educate and to perform assessment. Provide all members a scale. Increase utilization of vasodilator agent (ACE, AII, or ISDN/Hydralazine combination). Nutritional consult if indicated Refer to case management as needed	Complete assessment. 1 home visit by HHA nurse and more as needed. Call frequently to monitor symptoms, educate and to perform assessment. Provide all members a scale. Increase utilization of vasodilator agent (ACE, AII, or ISDN/Hydralazine combination). Nutritional consult if indicated Refer to case management as needed
Education	Mail AMERITIP on CHF Direct to 24/7 Nurse HelpLine	Teach basic facts about disease process, daily weights, symptom identification Discuss role of medications Develop self-management plan Discuss activity plan and dietary restrictions (2,000 mg diet) Include caregiver in instructions	Teach basic facts about disease process, daily weights, symptom identification Discuss role of medications Develop self-management plan Discuss activity plan and dietary restrictions (2,000 mg diet) Include caregiver in instructions
Telephonic Coordination of Care	Program Coordinator calls member within one week after ER visit; Case Manager calls member after discharge from hospital	Monthly for 3 months, then quarterly to verify compliance with action plan Once stable, refer to CHF Coordinator for quarterly telephonic follow-up	Monthly for 4 months (and as necessary, up to daily) to verify compliance with action plan
Physician Communication	Guidelines in provider manual Fax to PCP when member enrolled in program	Program Coordinator/Case Manager contacts PCP to review assessment and develop a treatment plan Program Coordinator communicates any changes in member's condition	Program Coordinator/Case Manager contacts PCP to review assessment and develop a treatment plan Program Coordinator communicates any changes in member's condition
Surveys/ Assessments	N/A	Completed at the beginning of the program and at least quarterly thereafter: Medical history, medication list and vasodilator status, and SF-12 survey	Completed at the beginning of the program and at least quarterly thereafter: Medical history, medication list and vasodilator status, and SF-12 survey
Reports	Monthly enrollment status Active/discharge status Monthly and quarterly outcomes Annual evaluation of program	Monthly enrollment status Active/discharge status Monthly and quarterly outcomes Annual evaluation of program	Monthly enrollment status Active/discharge status Monthly and quarterly outcomes Annual evaluation of program

Care Coordination for Asthma. Our DM interventions by risk level for asthma are shown in the following chart.

Process	Level I and II (Mild)	Level III (Moderate)	Level IV (Severe)
Surveys and Assessments	N/A	Clinical and environmental assessment	Clinical and environmental assessment

Process	Level I and II (Mild)	Level III (Moderate)	Level IV (Severe)
Education and Telephonic Care Coordination	Mail AMERITIP on asthma Nurse HelpLine	Teach basic facts about asthma Discuss role of medications Develop self-management plan Develop action plan for when and how to take rescue actions Discuss environmental controls to avoid If child, include caregiver education (provide Channing Bete education books)	Teach basic facts about asthma Discuss role of medications Develop self-management plan Develop action plan for when and how to take rescue actions Discuss environmental controls to avoid If child, include caregiver education (provide Channing Bete education books)
PCP Communication		DM staff fax PCP notice of member enrollment in program, program description, and practice guidelines Home health nurse contacts PCP to develop plan of care; communicates any changes in Member's condition identified during program	DM staff fax PCP notice of member enrollment in program, program description, and practice guidelines Home health nurse contacts PCP to develop plan of care; communicates changes in Member's identified condition during program
Care Coordination	Call within one week after any Member admitted to hospital	Quarterly phone call/compliance with action plan Refer to case management if acuity increases Refer to social worker/behavioral health/substance abuse as needed	Monthly phone call x3 and then quarterly/compliance with Action Plan Refer to case management if acuity increases Refer to social worker/behavioral health/substance abuse as needed
Home Health Visits		Three home health visits in two months Bi-weekly meetings with home health agencies for progress report Reevaluate for additional home health visits during telephonic follow-up Ensure all Members have peak flow meter Children <2 will need a nebulizer and a MDI with spacer holding chamber with face mask Children 3-5 years old may use MDI plus spacer/holding chamber	Three Home health visits in two months Bi-weekly meetings with home health agencies for progress report Reevaluate for additional home visits during each telephonic follow-up Ensure all Members have peak flow meter Children <2 will need a nebulizer and a MDI with spacer holding chamber with face mask Children 3-5 years old may use MDI plus spacer/holding chamber

Care Coordination for HIV/AIDS. Our DM interventions by risk level for HIV/AIDS are shown in the following chart.

Process	Level I HIV+ and Asymptomatic	Level II HIV+ and Symptomatic/Stable	Level III HIV+ with Opportunistic Infections or AIDS
Interventions	Complete initial assessment Monitor medication adherence Obtain current lab values: CD-4 count and viral load Assess condition monitoring Assess psychosocial and support status Identify recent healthcare services used Determine necessary referrals to community agencies and healthcare team	Complete initial assessment Monitor medication adherence Obtain current lab values: CD-4 count and viral load Assess condition monitoring Assess psychosocial and support status Identify recent healthcare services used Determine necessary referrals to community agencies and healthcare team	Complete initial assessment Monitor medication adherence Obtain current lab values: CD-4 count and viral load Assess condition monitoring Assess psychosocial and support status Identify recent healthcare services used Determine necessary referrals to community agencies and healthcare team

Process	Level I HIV+ and Asymptomatic	Level II HIV+ and Symptomatic/Stable	Level III HIV+ with Opportunistic Infections or AIDS
Education	Understanding of disease, transmission prevention, partner notification, reproductive counseling for women, disclosure of HIV status, supportive lifestyle actions, stress management, enrollment options	Understanding of disease, transmission prevention, partner notification, reproductive counseling for women, disclosure of HIV status, supportive lifestyle actions, stress management, enrollment options Tactics to minimize treatment side effects	Understanding of disease, transmission prevention, partner notification, reproductive counseling for women, disclosure of HIV status, supportive lifestyle actions, stress management, enrollment options Tactics to minimize treatment side effects Advance directives
Case Manager Contacts	Quarterly or more often as needed	Every 2 months or more often as needed	Monthly or more often as needed
Physician Communication: Physician Urgent Alerts and Routine Updates	Notify PCP of any new onset symptoms or condition changes or non-adherence to anti-retroviral or TB treatment Status update against case management goals every 6 months	Notify PCP of any new onset symptoms or condition changes or non-adherence to anti-retroviral or TB treatment Status update against case management goals every quarter	Notify PCP of any new onset symptoms or condition changes or non-adherence to anti-retroviral or TB treatment Status update against case management goals every quarter

Care Coordination for High-Risk OB. We recognize the importance of prenatal care and postpartum follow-up care for members who are expecting and offer our perinatal services program, *Taking Care of Baby & Me™*, to all pregnant members. This program combines OB care management with our award-winning health promotion educational materials. Through *Taking Care of Baby and Me*, we help pregnant women receive the necessary education, support, and assistance they need to have a healthy pregnancy and optimize maternal/fetal outcomes. Program features include:

- Prenatal questionnaire
- Care management by an OB specialist within 14 days of enrollment
- Risk assessment
- Prenatal and postpartum educational packet mailings
- Incentive gift program to encourage members to obtain necessary care throughout the pregnancy and after the baby arrives.

We conduct a prenatal survey to identify high-risk pregnancies, such as cases when the mother may be at risk for early delivery or birth complications. At-risk members participate in our High Risk OB Care Management Program. The initial OB assessment includes questions related to diagnosing depression. If a woman is found to be at risk for depression, we will coordinate care by referring her to a behavioral health specialist for comprehensive assessment and possible treatment. Through our regular contact with members and accompanying educational materials and incentives, we encourage members to adopt healthy pregnancy habits and to attend each of their prenatal and post-partum physician appointments.

We contact all pregnant members identified by state enrollment data, claims data, or self-identification at the time of enrollment or through contact with our Member Services Department. Upon this initial contact, expectant mothers are enrolled in the OB care management component of the *Taking Care of Baby and Me* program to ensure appropriate coverage for the member and eventually, her newborn. We also ensure that an appropriate PCP/specialist assignment has been made for the baby prior to delivery. This information is documented in our core operations system and in the member's plan of care. We require providers to adhere to specific appointment access standards for pregnant women:

- First and second trimester – within 7 days of the first request
- Third trimester – within 3 days of the first request
- High-risk – within 3 days of identification as high-risk or immediately for an emergency situation.

Through *Taking Care of Baby and Me*, we improve prenatal care compliance and pregnancy outcomes by:

- Increasing the number of prenatal visits
- Reducing fetal mortality
- Reducing premature births
- Reducing incidences of low birth weight
- Reducing NICU admissions, ALOS, and costs
- Increasing the number of postpartum checkups.

AMERIGROUP has established guidelines for caseload criteria in order to ensure optimum services are provided to members. Severity of cases, complexity of cases, and role requirements of Case Managers are used to determine staffing ratios. Clinical outreach and administrative Associates support these individuals. Disease Management Coordinators are all registered nurses who renew licensure every two years. They serve as clinicians, consultants, member advocates, educators, facilitators, and cost/financial managers. They coordinate services provided by the healthcare team (physicians, nurses, social workers, therapists, and other ancillary providers) to implement a plan of care to achieve positive patient outcomes and cost-effective utilization of services. DM Coordinators also function as a liaison between the member/family/caregiver and the healthcare team. DM Representatives identify and enroll members, screen and stratify members into appropriate care management groups, allocate cases to DM Coordinators, and document communication between AMERIGROUP DM staff, members, and providers.

Measurable Results. Typical measures used to evaluate the effectiveness of disease management programs include:

- Specific targeted health factors for disease-management-eligible members
- PCP visits
- Screenings and preventive care visits
- Inpatient hospital days
- ER visits
- Urgent care visits
- Home healthcare usage
- Medication usage
- Medical and pharmacy costs per disease-management-eligible member per month.

AMERIGROUP has achieved significant improvement in clinical outcomes and cost savings. For example, in 2004, we decreased total asthma costs by 31 percent ($1.51 per DM-eligible member per month, combining inpatient and emergency room costs) compared to 2003. This was driven by a 29 percent decrease in asthma ER utilization (0.31 visits per 1,000 member-months), a 15 percent decrease in asthma hospitalizations (0.18 admissions per 1,000 member-months), and a 49 percent decrease in asthma hospital-days (1.69 days per 1,000 member-months). We also increased the number of asthmatic members on appropriate medications by 5.5 percent.

Also in 2004, cost per CHF case decreased 2 percent, driven by a 2 percent decrease in ER utilization. The proportion of members with CHF on ACE/ARB therapy increased slightly from 64.1 percent to 64.9 percent, and members with CHF on beta-blocker therapy increased by 9 percent to 54.8 percent. Cost per diabetes case remained stable in 2004, driven by a 9 percent decrease in hospitalizations. Members with diabetes who had retinal exams in the first quarter increased by 18 percent to 65 percent; diabetics with LDL tests increased by 63 percent to 44 percent; diabetics with microalbumin tests increased by 30 percent to 13 percent; and diabetics with HbA1c tests increased by 40 percent to 49 percent. In 2004, cost per HIV case decreased by 3 percent, driven by a 3 percent decrease in hospitalizations.

We analyze the impact of our DM programs by reviewing member and claims information stored in our disease management and health plan outcomes tracking database. Local clinical staff and our home office Clinical Informatics team use this database and other applications to monitor, track, and trend disease management outcomes, analyze results, compare them to benchmarks and goals, and make improvement recommendations. The specific methods we use to assess outcomes include population and disease-specific approaches in which we calculate inpatient and ER utilization (IP/1000 and ER/1000) and compare costs for the current and previous years using the entire population or the disease-specific population as the denominator. We also calculate inpatient and ER utilization and costs for program participants for the six months prior to enrollment in a disease management program compared to the six-month post-enrollment period.

Additional Recommended Interventions. We recommend that the State include HIV/AIDS in its disease management programs serving the Medicaid population and consider initiating behavioral health disease management programs in the future.

Behavioral Health

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

AMERIGROUP's care management program is based on our Integrated Medical Management Model (IM3) and includes overall coordination of physical and behavioral health services. (Please see our response to Question 11.A for a complete description of IM3.) Under this model, behavioral health services are managed internally – they are not outsourced to a separate BHO. In our New York, Florida, Illinois, Texas, District of Columbia, Ohio, and Northern Virginia health plans, we offer the full continuum of behavioral health services. In Maryland, we provide substance abuse coverage. In New Jersey, we facilitate behavioral health care for members with developmental disabilities. In 2006, members with major depression and schizophrenia will be enrolled in formal disease management programs. Members with bipolar disorder and co-occurring mental illness/substance abuse receive care coordination through our centralized Behavioral Health Unit and BH Case Managers based in the local health plan.

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

AMERIGROUP performs behavioral health care management within our organization. In 2003, we expanded our Behavioral Health Services Division to support the needs of members in various markets. As part of our service expansion, we transitioned behavioral health services management from a subcontracted vendor to our internal department. Based on more than a decade of research, it has become

evident that a holistic system of care improves the overall level of service to members by integrating the physical, behavioral, and social aspects of treatment to maintain continuity of care.

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

Our successfully implemented care model now offers behavioral health services to more than 800,000 members. We use our Integrated Medical Management Model (IM3) and *Early Case Finding* to identify members needing behavioral health services and refer them to appropriate care coordination programs. Please see our response to Question 11.A for a complete description.

Care Management for Behavioral Health Services. AMERIGROUP's philosophy is to provide the care that is most appropriate to the member's need at the lowest intensity level possible. Rather than have patients spending long periods in the hospital, we prefer to use the hospital as an acute stabilizing environment and move members to less restrictive levels of care as soon as possible. This proactively manages medical costs without depriving the patient of needed care. At each health plan, Behavioral Health and Medical Case Managers meet and attend general medical rounds where specific clinical conditions are discussed. These staff members respond to requests for services from their counterparts as complex clinical conditions arise or when a combination of behavioral health and medical conditions are present. Following this collaboration, they then seek the appropriate services in the provider community and coordinate members' care to include treatment for physical, psychiatric, and substance abuse diagnoses and resultant symptoms.

Our Behavioral Health Care Managers use standard procedures for applying InterQual® criteria in making level-of-care decisions based on each member's presentation. The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, Care Managers consider the severity of illness and comorbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery. These criteria are used for precertification, concurrent review, and retrospective review for varying levels of BH services.

For example, we enroll all children age 12 and under who require psychiatric inpatient admission into our Case Management program upon discharge, regardless of their prior psychiatric history. Case Managers assess the child's home environment, family situation, and psychosocial needs to determine the best support system for recovery. They involve parents, guardians, and advocates in treatment planning as much as possible and may enlist the assistance of the treating provider or facility to encourage the family's participation. Care Managers and Case Managers may also authorize longer inpatient stays for children because of the complexities involved in their treatment needs and discharge planning.

At the time of authorization for inpatient, residential, or outpatient BH services, the Care Manager notifies the provider regarding procedures and criteria for medical review and continued stay. For the review itself, the Care Manager assesses appropriateness of continued care and the facility rendering services, assignment of length of stay, and assessment of quality concerns. The guidelines for concurrent review

are based upon InterQual criteria, evaluation of member's social and home environment, comparison to established practice guidelines and parameters, and timely adherence to the treatment plan.

AMERIGROUP performs concurrent reviews for all inpatient hospitalizations, residential stays, and intensive outpatient settings. Concurrent review assesses inpatient cases for: member progress, timeliness of care, appropriateness and level of care, and discharge needs required to support the transition from inpatient to outpatient care, such as outpatient services to be provided within 7 days of discharge. The Care Manager performs an initial review within 1 business day of admission notification by on-site review or telephonic communication with the hospital utilization management department. The Care Manager, in coordination with facilities or hospitals, initiates discharge planning on all patients and evaluates the need for case management. Retrospective reviews assess appropriateness of care, the facility providing care, and length of stay, based upon InterQual criteria.

When applying our BH utilization guidelines, certain criteria will identify members with chronic conditions or comorbidity who require more intense or integrated case management. Their care is managed by Case Managers (at the local health plan) who provide face-to-face consultation with members, providers, family members, and other key participants in the member's care.

All members identified as pregnant and needing substance abuse treatment services are referred to our high-risk OB case management program and our *Taking Care of Baby and Me* program for expectant mothers. We also consult with the member's psychiatrist and obstetrician regarding psychiatric medication management. As part of case management for pregnant or parenting members with a substance abuse disorder, we make referrals to community-based providers specializing in treating this population. Special considerations include the safety of the fetus or child, level of family support, home environment, substance abuse interventions, and child care issues.

For members with a dual diagnosis, we apply the review criteria to first determine the member's primary acute care need, with consideration given to the secondary condition. When it is possible to treat both conditions simultaneously, this is supported; however, the dual conditions may require a longer length of stay in order to stabilize them both. All inpatient BH facilities are required to maintain provisions (such as wheelchairs and other adaptive equipment) for members with physical disabilities. Our BH Case Managers coordinate discharge plans with medical care managers to ensure the member's needs will be met upon discharge. We also provide assistance to enroll the member in programs such as Meals on Wheels and other in-home services, if needed.

Staff Qualifications. Our Behavioral Health Division staff includes highly trained and appropriately licensed clinical and administrative professionals. The Division is led by our Vice President, Medical Management, who serves as the operational leader, and our Vice President, Associate Corporate Medical Director, who acts as the clinical leader and conducts reviews with psychiatrists, psychologists, licensed clinical social workers, and other behavioral health professionals. In addition, licensed professionals oversee Behavioral Health Clinical Access Line operations, utilization management, and training. Other staff includes:

- Behavioral Health Managers – provide direct supervision of the centralized behavioral health Clinical Access Line (Hotline) clinical and non-clinical staff
- Behavioral Health Referral Specialists – non-clinical Clinical Access Line staff who coordinate referrals for routine outpatient care and respond to member and provider inquiries regarding non-clinical issues.

- Behavioral Health Clinical Care Managers – Clinical Access Line staff who apply clinical criteria to evaluate requests for Precertification of behavioral health services, conduct concurrent reviews, and interface with health plan Behavioral Health and Medical Case Managers to coordinate members' care.
- Behavioral Health Case Managers (based in local health plan) – registered nurses or licensed clinical social workers with a minimum of three years' behavioral health experience who provide clinical case management and coordinate care with Behavioral Health Clinical Access Line staff and Medical Case Managers for members with comorbid conditions.

Examples of Measurable Outcomes. In our Texas market, integrated care management has resulted in improvements in patient outcomes and cost savings for the State. The Intensive Case Management Program that focuses on stabilizing the member's condition through coordinated medical and behavioral health interventions saved approximately $150,000 during its first nine months. Texas members with severe and chronic mental illness are part of the *Rising Star* Program in which the member selects a psychiatrist and a "home" hospital. Coordination of care under this program reduced medical, behavioral, and pharmacy expenses for those enrolled by 25 percent. The most recent Texas PCP-based Adolescent Depression Screening initiative demonstrated a 41.9 percent screening rate, a significant improvement since the program was launched in October 2004.

In Florida, we created an Eating Disorder Task Force to address the physical and behavioral healthcare needs of young women diagnosed with this condition. This program has reduced inpatient costs and shown health improvements for members. Since integrated behavioral health services have been in place in our Florida market, our customer satisfaction rating has improved, including a 10 percent increase in members' "access to treatment and information" and an improvement in 13 of 17 attribute scores.

G. Capitation Model

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.

All of AMERIGROUP's 10 contracts are full risk contracts. We have more than 10 years' experience operating under risk-based contracts for Medicaid. Through our years of experience, we have seen the following advantages to risk-based arrangements validated time and time again.

- Significant cost savings − full-risk managed care provides the managed care organization with incentives to manage costs and care effectively
- Budget predictability, allowing the State to:
  - Set the price for the Medicaid program
  - Shift utilization risk to the MCO
  - Meet the needs of high-cost populations (e.g., SSI) in a more coordinated, administratively efficient, and cost-effective manner
- A coordinated, community-based system of care for Medicaid recipients
  - A four-part model that:
    - Ensures access – each Medicaid beneficiary has a medical home
    - Enables care -- *Early Case Finding*^{sm}, case management, disease management
    - Focuses on preventative health care, removing barriers to care
    - Supports providers -- a physician responsible for coordinating and guiding members' care via the medical home model
- Community organizations are engaged as partners to facilitate access to and coordination of care

- Improved health outcomes
  - "A recent study on quality oversight in Medicaid PCCM programs found that the majority of Medicaid PCCM programs are not yet using the quality measurement, feedback, and improvement strategies that are often required of MCOs."… "Similarly, FFS programs conduct minimal quality oversight."*
  - NICU admissions as low as 3.5% for those members participating in AMERIGROUP's pre-natal program compared to an 11% benchmark**
  - Emergency room visits down 20% in 2003 from 2002***
- Full-risk managed care is accountable to members, providers, and states – quality monitoring and HEDIS reporting, state-specific fiscal, and operational standards.

Sources:
* Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program; The Lewin Group, May 2005
** "Neonatal Care Management" Disease Management Outcomes 2001; 9 (6)
*** AMERIGROUP results

Concerns. It is our hope that TennCare provide a procurement process that is inviting to MCOs new to the market. The following concerns come from lessons we have learned through the years and from research of other Medicaid managed care programs. Following this list of concerns, we provide related recommendations.

- Should the State decide to award to more than two to three MCOs, membership levels can be too low for MCOs to maintain financial viability
- Without an established minimum level of membership or assignment algorithm, membership can be inequitably distributed among the participating MCOs, thereby making it difficult for MCOs to maintain financial viability
- The development of strong provider networks is important to establishing a program that is stable, that efficiently uses the State's funds, and that provides continuity of care by providing a medical home for members. Participation of out-of-network providers can be difficult to obtain.
- Risk can be inadequately estimated if the State's rates are not actuarially and financially sound and if the rates are not based on good historical claims data.

Recommendations. Based on the knowledge we have gained during the past decade, and given our concerns listed above, we recommend the following for the TennCare's capitated managed care program:

- AMERIGROUP supports Tennessee's plan to limit contract awards to two MCOs. Such an arrangement would be administratively simpler for the State, less confusing to enrollees, and would provide each MCO with adequate membership levels to meet requirements related to minimum covered lives.
- We recommend minimum levels of membership to promote the equitable distribution of membership to help ensure MCOs' financially viability.
- To promote the participation of out-of-network providers, AMERIGROUP recommends a requirement similar to that employed in Georgia where MCOs are required to make three earnest attempts to contract with out-of-network providers. After three unsuccessful attempts by the MCO, the out-of-network providers would be reimbursed at 90% of the Medicaid fee schedule. This requirement provides incentive for out-of-network providers to contract with an MCO thereby improving access for enrollees and controlling costs.
- We recommend the State implement a requirement that members remain with their chosen MCO for 12 months after an initial open enrollment period. This prevents members from changing MCOs too

often and allows the MCOs to establish a medical home for members and help establish continuity of care.

- We recommend the State ensure rates are actuarially sound based on several years of claims data to minimize risk and that the State allow for the ability to adjust for population mix and risk factors, promoting program stability.

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

A full-risk capitation environment would positively affect AMERIGROUP's decision to participate. AMERIGROUP supports the State's move to a full-risk capitated environment. Under a full-risk capitated environment, a MCO has incentive to manage the members' care in the most appropriate setting, risk is shifted from the State to the MCO, budgets are more predictable, community organizations are engaged, states experience cost savings, and there is a focus on preventative care. Details of these advantages of full-risk capitated environments are outlined in our response to 11.G.1.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

For the reasons stated in our response to 11.G.1., AMERIGROUP prefers a full-risk arrangement and has extensive experience managing such risk. Variations to the full risk approach such as those listed below do occur in other Medicaid managed care contracts. AMERIGROUP has experience with approaches similar to these others.

a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)

Although AMERIGROUP prefers full-risk arrangements (as stated above), this arrangement would not preclude AMERIGROUP from considering this type of opportunity.

b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)

Although AMERIGROUP prefers full-risk arrangements (as stated above), this arrangement would not preclude AMERIGROUP from considering this type of opportunity.

c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)

Although AMERIGROUP prefers full-risk arrangements (as stated above), this arrangement would not preclude AMERIGROUP from considering this type of opportunity.

d. Other

Not applicable.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

Yes, AMERIGROUP's participation depends on a minimum of 50,000 covered lives.

H. Data and Systems Capability

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

For our nine live Medicaid client contracts (Florida, Illinois, Maryland, New Jersey, New York, Ohio, Texas, Virginia, and the District of Columbia), AMERIGROUP has a proven track record of generating compliant, timely and accurate reports on a weekly, monthly, quarterly, annual, and ad-hoc basis. AMERIGROUP uses experienced teams to manage and execute the reporting processes that support each AMERIGROUP health plan's financial and nonfinancial performance data compilation and reporting. These teams include subject matter experts (SMEs), Regulatory Compliance Department, and Regulatory Reporting Department. AMERIGROUP has extensive experience providing each of our clients with reports that include the following data:

- Eligibility/enrollment
- Claims/encounter data
- Checks, Explanations of Payment (EOP), and Explanations of Benefits (EOB)
- Financial data
- Prior authorization data
- EPSDT services information
- Medical management information
- Quality assurance information
- Concurrent review information
- Health education information
- Member and provider services information
- Member satisfaction information
- Member and provider appeals and fair hearings data
- Member and provider grievances and disputes data
- Fraud and abuse information.

Our core operations system and data marts we maintain provide us with the capacity to readily obtain and provide the data listed above.

Encounter Reporting. AMERIGROUP has an encounters management system and formal processes in place to ensure the timely and accurate submission of encounter data according to the requirements of the contract, including media and file format requirements and submittal timeframes. We actively work with states to ensure complete, accurate, and valid encounter data is transmitted each month. For our existing health plans, AMERIGROUP submits monthly encounters and complies with each state's certification process.

We use our encounters management system to consolidate the data we receive from our ancillary vendors and all the claims/claims adjustment data processed by our core operations system since the last submission of encounter records. The system includes a scheduling routine that ensures we process all new and any revisions or additions to encounter data on a monthly basis for submission to each state.

The encounters management system receives input from the core operations system database and our vendor databases, performs edits to ensure we do not process duplicate claims, verifies and validates member and provider numbers, and validates record counts. The encounters management system also invokes a series of business rules to ensure our claims records meet each state's processing requirements, including checking for the validity of such data as diagnosis codes, procedure codes, revenue codes, and dates of service.

The encounters management system formats claims records that pass all edits in HIPAA-compliant formats. We transmit our encounter data to our clients electronically and meet each state's individual requirements for secure electronic transmissions. Our encounters management system allows AMERIGROUP to meet each state's requirements by:

- Integrating service and encounter data
- Applying state-appropriate business rules and data edits
- Producing 837 I, P, and D encounter extracts according to HIPAA Companion Guides
- Producing pharmacy transactions in NCPDP formats
- Supporting encounter data validation and reconciliation efforts.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

AMERIGROUP implements a Quality Management (QM) Program, including a QM Department, at each local health plan to encompass both clinical care and services provided to our members, provider network, governmental agencies, and AMERIGROUP Associates, with oversight from our home office. We use a QM information system and data marts to incorporate data from other management functions as well as enabling our QM Department to monitor quality issues from institutional, non-institutional, primary, and specialty services. We establish an annual QM Work Plan that identifies clinical indicators and studies to be conducted and monitored based on the individual plan's demographic and epidemiological data. AMERIGROUP is committed to:

- Monitoring and improving quality of care provided to members through a commitment to safe clinical practice in the following areas:
  - High volume, high cost, high risk services, and/or problem prone areas identified through review of demographic and epidemiologic membership data
  - Services provided in hospitals, home health, skilled nursing facilities, free-standing surgery centers, Federally Qualified Health Centers (FQHC), and behavioral health facilities
  - Services provided by individual providers (primary care, Obstetrics/Gynecology, high- volume specialty care, mental healthcare)
  - Acute, chronic and preventive physical and mental health services
  - Medical records review
  - Clinical practice guidelines
  - Services reflecting disease management of chronic illnesses and special needs
  - Continuity and coordination of care
  - Under and over utilization of services
  - Clinical indicators.
- Monitoring and improving quality of services to safeguard members, including the following areas:
  - Primary care practitioner accessibility and availability

  - Urgent care accessibility
  - Specialty care practitioner availability
  - Plan accessibility (i.e. member services, Nurse Help Line)
  - Member satisfaction
  - Complaint, grievance, and appeal monitoring and analysis
  - Credentialing and recredentialing processes
  - Privacy compliance.
- Monitoring and improving the performance indicators of health plan and service center functional areas:
  - Provider satisfaction
  - Departmental service indicators (Member/Provider Services, Network Support, Medical Management).

AMERIGROUP providers are reminded of their role and responsibilities through our Provider Manual, which details both provider and member responsibilities. The local health plan management team handles issues with providers who do not comply with the requirements. Follow-up may include a meeting or phone call with the Provider Relations Manager, Medical Director, or other health plan senior staff. In all cases, an action plan is put into place that documents the relevant issues and tracks resolution and closure.

Oversight of subcontractors providing health care services occurs locally through each health plan's Medical Advisory Committee and at the corporate level through AMERIGROUP Corporation's Vendor Selection Oversight Committee (VSOC).

The VSOC includes members from corporate departments and health plans who are involved in the daily management of subcontractors or who are responsible for monitoring delegated activities. The VSOC does the following:

- Reviews required, periodic management reports
- Conducts readiness reviews and annual on-site audits of delegated services
- Facilitates semi-annual joint operations meetings between AMERIGROUP and each subcontractor
- Monitors the subcontractor's financial stability in the case of delegated financial risk arrangements or claims processing.

I. Net Worth and Restricted Deposit Requirements

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

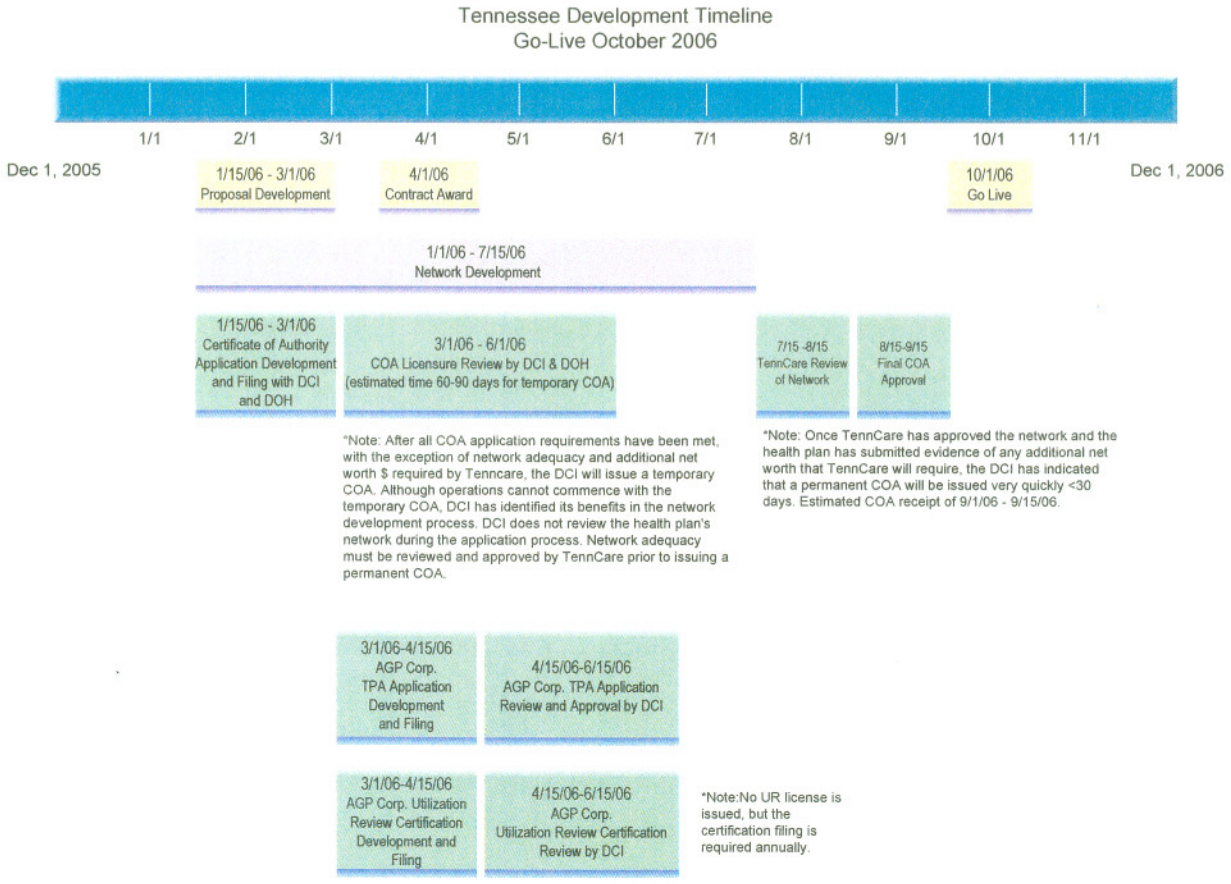
No, we do not consider the net worth and depositing requirements to be a deterrent to contracting with TennCare.

J. Implementation Timeframe

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

The anticipated timeframe for procurement and implementation will impact AMERIGROUP's decision to participate in this program. The time the State allocates to implementation is a critical component to TennCare's success, particularly for new market entrants. The timeline for the procurement, e.g., RFP

release, proposal submission, open enrollment, etc., are significant when you overlay the Department of Commerce and Insurance's (DCI's) requirements and timeline for MCOs obtaining their appropriate licensure. Depending on the details of TennCare's schedule of events particularly as they relate to the provider network contracting, AMERIGROUP is concerned there will not be sufficient time available to build a quality network and meet the other requirements for an October 1, 2006 start. The chart below provides our graphic illustration of known key procurement and DCI events, per state regulation, required to go live by October 2006.



Given the challenges TennCare's program administration, provider community, and members have faced in recent years, we are concerned about providers' willingness to contract with MCOs. Additionally, AMERIGROUP would ask the State to provide adequate time for new MCO entrants to recruit enough providers and specialists to develop a network capable of meeting and exceeding access standards. Specific concerns about the anticipated April 2006 contract award and October 2006 implementation date are:

1. Adequate time to develop a broad, comprehensive provider network.
2. RFP requirements regarding the submission of a contracted network with the proposal.
3. Timeframes for member marketing and enrollment and their related impact on the deadlines for provider network development.
4. Timely availability of a complete Data Book.
5. Ability to work with the State to understand TennCare's rate-setting methodology.

Our recommendations for how the State can address our concerns are provided below in our response to J.2. Our comprehensive implementation methodology is managed internally by our implementation team and it is the backbone of daily planning and execution. In all cases, continuity of care for members and a smooth transition for our providers is our top priority. Our project management and implementation tools have been tested, verified, refined, and improved by the experience gained with each successful implementation. We pride ourselves on working collaboratively with our state partners to develop innovative programs that simultaneously achieve quality of care and cost containment goals.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

AMERIGROUP requests the State allow bidders 90 days to respond to the TennCare Request for Proposals. Additionally, given our experience implementing risk-based Medicaid managed care programs and transitioning members, we recommend the State allocate a minimum of six months, with consideration of an optimal timeframe of nine months, for program implementation. Specific recommendations related to the issues identified in our response to J.1 are:

1. Given the tight timeline discussed in this RFI, we recommend the RFP not require a contracted network for the RFP response. Developing relationships with providers and hospitals and building a network requires significant time and investment on the part of the MCOs. It is our experience that providers are reluctant to commit to negotiating and signing a contract with MCOs prior to contract award. Instead, we recommend the State:
    - Require bidders to submit a network development plan and any provider Letters of Intent with the proposal submission.
    - Conduct a network adequacy review of the awarded MCOs' as part of the readiness review.
    - Require awarded MCOs to have their contracted network in place for Open Enrollment.
2. To ensure equitable opportunity for all bidders, new HMOs and incumbents, we recommend the State exclude the network size/adequacy from the scoring of the proposals.
3. Open enrollment should last a maximum of 60 days, prior to start-up. A longer enrollment period would shorten the time for network development.
4. Distribute a Data Book with 3-5 years of historical data on or before the RFP release date.
5. Review the State's rate-setting methodology with potential bidding MCOs.

All of AMERIGROUP's recommendations provided herein are presented in the spirit of collaborating with the State to solicit strong, viable companies to bid on the RFP, develop an effective program that meets the needs of the members, ensure efficient use of the State's funds, and improve health outcomes of TennCare members. We appreciate the opportunity to provide our input.

Summary

AMERIGROUP looks forward to receiving the RFP for the TennCare procurement. We recognize and appreciate the experience the State has had with the TennCare program, as well as where the State wants to take the program. Throughout our more than 10 years as Medicaid managed care organization, we have seen many variations of programs consulting with many states to help them understand the pros and cons of program design. Taking into consideration TennCare's approach outlined in this RFI, there are

key points we would like to make with respect to program components that we feel are important to a successful transition.

- **Mandatory enrollment.** AMERIGROUP supports an annual open enrollment period where members are allowed to select an MCO and if no selection is made, then the State would auto-assign the member per a pre-determined algorithm. We recommend the State allow a 30 to 60 day period after the open enrollment when a member can change their MCO assignment. After that period the State should lock-in the member for the remainder of the 12 month period providing stability to the healthcare service delivery and care management. Mandatory enrollment with the ability for members accomplishes the following:
  - Provides members an opportunity to experience the benefits of a medical home and care coordination.
  - Gives members sufficient time to learn about their MCO, their health options, and ways to access care.
  - Provides a mechanism for the MCOs to obtain a large enough membership to help their financial viability

- **Limiting the number of MCO awards to a maximum of three.** Limiting the number of MCOs in the market to no more than three helps ensure enough membership to promote financial viability for the MCOs.

- **MCO covered services should include LTC services.** AMERIGROUP has found that managing the full continuum of services for the member takes the greatest advantage of coordination of care. Our experience in managing the members who are in LTC services offers the member new choices where many are able to stay within the community, reducing the costs of their care and providing increased satisfaction for the member. Advantages of including long-term care in the program benefits are:

  - Members will receive a level of continuity of care that promotes better health outcomes
  - Provides an effective avenue for MCOs to place LTC members in the most appropriate setting which in many cases is in community based programs and out of nursing homes
  - Reduced institutional costs
  - Increased member satisfaction.

- **Out-of-Network provision.** As the TennCare program transitions to the full-risk model, the development of new networks broad enough to provide excellent access for members is critical. As has been done in other States, e.g. Georgia Cares Program, the State should establish a solid out-of-network provision. A requirement that provides incentive for out-of-network providers to contract with MCOs improves access for enrollees and helps controls costs.

- **Integrated mental health benefits.** AMERIGROUP is committed to the integration of physical and behavioral health as the best solution for the member and the program. We do have experience with other models but have found that the integrated model provides the best care management for the member.

- **Quality measures.** AMERIGROUP encourages the State to rely on real measures of quality, such as NCQA accreditation, HEDIS, etc. AMERIGROUP supports the measurement of quality based upon health outcomes.

- **Financially sound rates.** While CMS now requires rates to be "actuarially sound," this standard is only a measure of the adequacy of the methodology for calculating the rates. We encourage the State to ensure the rates are "financially sound" or adequate to provide the services required by the contract, while allowing the MCO sufficient funds to cover administrative costs of capital and normal profit requirements. AMERIGROUP, as any MCO, evaluates each opportunity as an investment seeking to cover costs and make a reasonable return on that investment. AMERIGROUP would welcome the opportunity to meet with the State and its actuaries to discuss this in greater detail.